STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155697	B. WIN	IG		07/20/	/2012
NAME OF E	PROVIDER OR SUPPLIE	D	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	ROVIDER OR SOLI EIE.	R		517 N L	ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTE	R	CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
			F00		l		
	This visit was for Investigation of		F00	000	This provider respectfully		
	Complaint IN00	0112646.			requests that the 2567 plan of correction be considered the		
					letter of credible allegation and	d	
	Complaint IN00	112646 - Substantiated.			requests a desk review on or		
	Federal/state de	ficiencies related to the			after August 17, 2012.		
	allegations are c	eited at F257, F309, F514,					
	and F517.						
	Unrelated defici	iency is cited.					
		J					
	Survey dates: I	uly 18, 19, and 20, 2012					
	Survey dutes. 3	ary 10, 17, and 20, 2012					
	Facility number	. 000059					
	Provider numbe						
	AIM number: 1						
	Alivi humber. 1	100266360					
	G	. D. A. IV. D.V.					
	Survey team: Je	ennie Bartelt, RN					
	Census bed type	2.					
	SNF: 4						
	SNF/NF: 66						
	Total: 70						
	Census payor ty	rpe:					
	Medicare: 9						
	Medicaid: 49						
	Other: 12						
	Total: 70						
	Sample: 9						
	These deficienci	ies reflect state findings					
	Those deficient	105 Torroot State Infamigs					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 155697	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/20/2012				
	PROVIDER OR SUPPLIER REHABILITATION AND SKILLED NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION				
	cited in accordance with 410 IAC 16.2. Quality review completed on July 25, 2012 by Bev Faulkner, RN							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet

Page 2 of 34

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155697	B. WIN			07/20/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0257 SS=E	483.15(h)(6) COMFORTABLE LEVELS	& SAFE TEMPERATURE					
	The facility must safe temperature certified after Oc	provide comfortable and e levels. Facilities initially tober 1, 1990 must maintain inge of 71 - 81° F					
	Based on observative record review, the residents' room emaintained in corranges for 4 of 4 rooms were obsettemperatures out.	ation, interview, and the facility failed to ensure environments were mfortable temperature residents in whose enved to have side the range of 71 to 81 teit in the sample of 9.	F02	57		nts y ent hat een is ge	08/17/2012
	Findings include: During interview on the Initial Tour on 7/18/12 at 4:35 p.m., the Interim Administrator indicated the facility recently had problems with the air conditioning system. She indicated the system had malfunctioned on Friday (7/13/12), was repaired on Saturday (7/14/12), but a power surge in the city on Tuesday morning (7/17/12) had caused another malfunction of the system. She indicated the facility's regular heating and cooling service provider, and another heating and cooling service provider, had repaired the system on Tuesday (7/17/12). She indicated supplemental portable air conditioners and large floor fans had been				within normal temperature range of 71-81 degrees. Resident G's room is within normal temperature range of 71-81 degrees. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by the alleged deficient practice. All PTAC units within the facility were checked on or by 8/13/12 to ensure proper functioning. All rooms within the facility were checked on or by 8/13/12 to ensure temperatures were within normal range of 71-81 degrees. Hot water pipes within the facility have been checked on or by 8/3/12 and all pipes indicating leaks have been repaired by 8/3/12.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet

Page 3 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155697	B. WING		07/20/2012
N	DOLUBER OF START			ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			ITTLE LEAGUE BLVD	
		ND SKILLED NURSING CENTER		SVILLE, IN 47129	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	, The state of the	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	installed in the ha	allways in the meantime.		delivered on or by 8/13/12 to	
	She indicated she	e had been told that the		ensure the temperatures within	
	system was repai	ired at midnight on		the building are between 71-8 degrees while the repairs to or	
	1 -	ld be functioning at		existing chiller unit take place,	
		g capacity at midnight on		ensuring our current system w	
		able air conditioner with		permanently reach its maximu	
	_			cooling potential. What	
	_	nearby was observed on		measures will be put into place	
	•	20, and Hall 40. A large		what systematic changes will l	
		served on Hall 60. A		made to ensure that the defici-	ent
	thermometer on	the wall near the portable		practice does not recur? Resident rooms on each ha	
	air conditioner or	n the 40 hall registered		and common areas will be	III
		enheit (F). The Interim		checked by	
	_	dicated the halls and		Maintenance/Designee daily to	
		re cooled by the facility's		ensure temperature is maintai	
				between 71-81 degrees.	
	chillers, with in-			·All PTAC units within the	
	_	TAC (Packaged Terminal		facility were checked on or by	
		units. She indicated the		8/13/12 to ensure proper	
	Main Dining Roo	om and Therapy Room		functioning. ·All rooms within the facility	
	are cooled by sep	parate air conditioning		were checked on or by 8/13/12	2 to
	units, and the Ma	ain Dining Room and		ensure temperatures were wit	
		vere cool when the		normal range of 71-81 degree	
		building became warm		·Hot water pipes within the	
		nction of the chiller		facility have been checked on	
	_			by 8/3/12 and all pipes indicat	ing
	*	erim Administrator		leaks have been repaired by	
		its had been encouraged		8/3/12.	ho
		the Main Dining Room		·A temporary chiller unit will delivered on or by 8/13/12 to	ne
		om during the problem,		ensure the temperatures within	n
	families had been	n notified of the problem,		the building are between 71-8	
	fans had been pla	aced in residents' rooms,		degrees while the repairs to o	
		nts had complained. The		existing chiller unit take place,	
	Interim Administ	•		ensuring our current system w	
		he hallways were being		permanently reach its maximu	m
	-	-		cooling potential.	
		erim Administrator		How the corrective action will monitored to ensure the defici-	
	indicated Resider	nt C was in process of		monitored to ensure the delich	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet Page 4 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJI	LDING	00	COMPLETED	
		155697	A. BUI B. WIN	LDING		07/20/2012	
		ı	D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			LITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER	₹		SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	, · · · · · · · · · · · · · · · · · · ·	(X5)	
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	``	LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	moving out of he	er room to another room,			practice will not recur, i.e., who		
	as her room was	too warm, and packed			quality assurance program wil	l be	
		observed in the hallway			put into place?		
	near the resident				 Maintenance Director/Desig will provide operation checks to 		
					the chiller system to ensure		
	During interview	v on 7/18/12 at 7:00 p.m.,			proper functioning weekly x 4,		
	the Interim Administrator indicated her				bi-weekly x 2 months, monthly	′ x3	
					and quarterly thereafter for 2		
		e for all areas of the			consecutive quarters. Maintenance Director/Designe	90	
		tween 71 and 81 degrees			will provide operation checks		
		reiterated that logs were			the PTAC units in resident roo		
	_	d for temperature in the			to ensure proper functioning		
	1	at the system would be at			weekly x4, bi-weekly x2 month	η,	
	its peak potentia	l at midnight.			monthly x3 and quarterly		
					thereafter for 2 consecutive quarters. Maintenance		
	During interview	v on 7/20/12 at 1:20 p.m.,			Director/Designee will keep a		
	the Interim Adm	inistrator indicated she			temperature log to ensure the		
	had not yet recei	ived the expected bid			building is within normal		
	I -	's heating and air service			temperature range weekly x4,		
		d to the final repair of the			bi-weekly x2 months, monthly	x3	
		ditioning system. She			and quarterly thereafter for 2 consecutive quarters. The		
	1 -	is expecting it to come at			results of these audits will be		
	any time.	is emporting it to come ut			reviewed by the CQI committee	e.	
	any time.				If threshold of 95% is not		
	1 During chase	vation in the room of			achieved an action plan will be		
	_	vation in the room of			developed to ensure complian	ce.	
		118/12 at 5:20 p.m., a					
		ge reading indicated 85.9					
	~	measured in the vicinity					
		F was seated in his wheel					
		ΓAC unit. No fan was					
	observed in the i	room, and Resident F had					
	no water or water	er pitcher nearby. Air					
	was blowing from	m the unit, but the air did					
	1	he touch. During					
	interview at the						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155697	A. BUI	ILDING	00	COMPI	
		155697	B. WIN			07/20	/2012
NAME OF F	PROVIDER OR SUPPLIER	2			DDRESS, CITY, STATE, ZIP CODE		
		AND SKILLED ALLIDSING CENTE	D		ITTLE LEAGUE BLVD		
		AND SKILLED NURSING CENTE	K 	CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX TAG	,	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	COMPLETION DATE
IAG		opened his windows		IAG			DATE
		•					
	1	to try to get some cool					
		the lady that runs this					
	_	d she told him to close					
		the PTAC could cool the					
		ent indicated, "I'm					
		log" and "It's too hot to					
	_	ated the air coming from					
		ing unit was not cool.					
		icated he kept wiping his					
		wash cloth to keep cool,					
	_	o a wash cloth folded on					
		resident indicated he did					
	_	lass or water pitcher in					
		esident indicated the					
	pitcher and cup of	on the overbed table next					
	to the roommate	's bed belonged to the					
	roommate.						
l	At this time, the	Interim Administrator					
ı		and discussed the room					
		k of fan, and lack of ice					
	_	nt F. At this time,					
		ated he did not like the					
		r at the facility. The					
		trator indicated the					
		ave bottled water. Other					
	1	offered. The Interim					
		ft the room, and at 5:25					
		ntered the room with ice					
	_	nt F's roommate, and the					
		trator entered with water					
		The Maintenance					
		entered the room,					
	Supervisor also t	ontered the room,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet

Page 6 of 34

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		NSTRUCTION 00	COMPL	
		155697	A. BUILDIN B. WING	U		07/20	/2012
NAME OF I	PROVIDER OR SUPPLIER	,		TREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
					ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER	R C	LARKS	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES	I		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		AG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
TAG		erature gauge device, and	1.	40			DATE
		temperature was 88					
		Maintenance Supervisor					
		C and indicated it					
		en - it's not clicking					
	_	The Maintenance					
	_	ated the unit was not					
	_	, although staff tended to					
	*	out the unit was part of					
		n, which operates by					
	I	ving through the system,					
	with controls roc	om by room to adjust the					
	temperature in re	esidents' rooms. The					
	Maintenance Sup	pervisor obtained tools,					
	removed the fror	nt of the air conditioning					
	unit, made adjus	tments, and air cool to					
	the touch began	to flow from the unit.					
		ninistrator brought in and					
	set up a fan in th	e resident's room.					
	_	iew on 7/18/12 at 5:35					
	1	indicated her room was					
		stay in. She indicated it					
		ght before, she had to					
	_	on her body to stay cool.					
	She indicated she						
	· ·	e hot, humid air made it					
	_	er to breathe easily and					
	^	were observed blowing					
		The resident's family he bedside and indicated					
		acility two months ago					
		ditioning system was first					
		e system was not					
	turned on that the	c system was not					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet

Page 7 of 34

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2012 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/20/2012
	PROVIDER OR SUPPLIEI	R AND SKILLED NURSING CENTEI	517 N	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD KSVILLE, IN 47129	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	indicated the consystem "put on a fixing the system member indicated reading in the rewhen he arrived indicated the roof family member but he "went off problem. The remember indicated move to another The family mem with the air concompounded by the facility. The warm to the feet shoes. On 7/18/12 at 7: interview was concompounded by the resident indicated the roof of the resident indicated the shoes.	a leak of hot water under a floor was observed to be through the soles of the floor was observed to be through the soles of the floor was observed to be through the soles of the floor was waiting for good the floor was observed to be the floor was observed to be through the soles of the floor was observed to be through the soles of the floor was observed to be through the soles of the floor was observed to be through the soles of the floor was observed to be through the soles of the floor was observed to be through the soles of the floor was observed to be through the soles of the floor was waiting for good the floor was waiting floor was waiting for good the floor was waiting floor was waiting for good the floor was waiting			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet

Page 8 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155697	B. WIN			07/20/	/2012
			1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R		517 N L	ITTLE LEAGUE BLVD		
		AND SKILLED NURSING CENTER	₹	CLARK	SVILLE, IN 47129		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		40 p.m., Resident C was					
	_	transfer from bed to					
	wheel chair by Hoyer lift. During the						
	<u> </u>	esident was lowered into					
	•	sident indicated, "I can't					
	breathe. Let me	breathe." The					
	temperature in the	ne room measured 86.6					
	degrees F. The	resident was wheeled out					
	of the room at le	east four hours after the					
	initial plan for th	ne move to a cooler					
	location.						
	3. On 7/18/12 a	t 6:55 p.m., the					
		he room of Residents G					
	_	ured at 86 degrees F.					
		observed in bed with					
		partially closed around					
		es were closed, and his					
	1	e even. His supper tray					
	-	bed table in front of him.					
	_	e Maintenance Supervisor					
		mperature at 94 degrees F					
		ring interview at this					
	· ·	ed the hot water leak					
	_	nt C's room was also					
	_	om. He indicated his					
	temperature mea	asurement was related to					
		g a temperature reading					
	from the floor of	f the room.					
	On 7/18/12 at 8.	00 p.m., Resident H had					
		oom. He was seated in					
		manipulating oxygen					
	tubing for his na	sal cannula. Resident H					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet

Page 9 of 34

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2012 FORM APPROVED OMB NO. 0938-0391

		TION NUMBER:	A. BUIL B. WINC	DING	00	COMPLETED 07/20/2012	
	ROVIDER OR SUPPLIER	ED NURSING CENTER		517 N L	DDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID PREFIX TAG	SUMMARY STATEMENT O (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENTIF	PERCEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	indicated, "It's pretty dagged than fire - in here." He indopened the window to get a time, the Interim Administ the room and offered to me H and G to a cooler room, indicated they wanted to st room. Resident H said about "He can take the heat bette CNA #12 entered the room Resident G's tray. She ask "Are you hot, too?" She indidn't eat much except his esupper. This federal tag relates to CIN00112646. 3.1-19(h)	icated he had hir. At this rator entered ove Residents but both hay in their own but Resident G, r than I can." hat to remove ed Resident G, dicated he dessert for					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet Page 10 of 34

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155697	B. WIN	G		07/20/	2012
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER	₹	CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0309 SS=D	483.25 PROVIDE CARE WELL BEING Each resident m must provide the services to attain practicable phys psychosocial we the comprehens care. Based on observe interview, the fact residents were the including vital sit conditioning mail residents' rooms The deficient pra residents reviewed diagnoses in a sat and E) Findings include During interview 7/18/12 at 4:35 p Administrator in recently had prof conditioning sys system had malfit (7/13/12), was re (7/14/12), but a p Tuesday morning another malfunct indicated the fact cooling service p	ust receive and the facility encessary care and or maintain the highest ical, mental, and II-being, in accordance with ive assessment and plan of ation, record review and cility failed to ensure foroughly assessed, gns, when an air affunction caused to be unusually warm. In actice affected 2 of 2 ed related to respiratory emple of 9 (Residents C	F03		What corrective action(s) will accomplished for those reside found to have been affected be the deficient practice? Reside C has been moved to a room is within normal temperature range of 71-81 degrees and monitoring daily to ensure no signs and symptoms of distrestores. Resident E's room is within normal temperature range of 71-81 degrees. How other residents having the potential be affected by the same deficipractice will be identified and what corrective actions will be taken? All residents have the potential be affected by the alleged deficient practice. The licensed nurses will be serviced by the DNS/designer or by 8/14/12 on licensed staff resident care rounds to identification, including assessing residents daily. All residents will be assessing the condition, including assessing residents daily. All residents will be assessing the condition assessing the components of the components and the components are components and the components and the components are components and the components are components and the components are components.	ents y ent that to ient in e on f y ed	08/17/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet

Page 11 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLE	TED
		155697	B. WIN			07/20/2	.012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF P	PROVIDER OR SUPPLIEF	8			LITTLE LEAGUE BLVD		
	REHABILITATION A	ND SKILLED NURSING CENTER	₹		SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	repaired the syst	em on Tuesday (7/17/12).			physician will be contacted for	I .	
	She indicated sh	e had been told that the			those presenting with a chang condition for further orders.	e in	
	system was repa	ired at midnight on			·The DNS/Designee will be		
	7/17/12 and wou	ld be functioning at			responsible to ensure		
	maximum coolir	ng capacity at midnight on			compliance.		
	7/18/12.				Non-compliance will result i	in	
					further education including		
	1 During inters	iew on 7/18/12 of 5-25			disciplinary actions.		
	_	iew on 7/18/12 at 5:35			What measures will be put into place or what systematic chan	I .	
	* '	indicated her room was			will be made to ensure that the	-	
		stay in, since the air			deficient practice does not rec		
	_	s not working correctly.			·The licensed nurses will be		
	She indicated it	was so hot the night			serviced by the DNS/designee		
	before, she had t	o have ice placed on her			or by 8/14/12 on licensed staff		
	body to stay coo	 She indicated she has 			resident care rounds to identify	У	
	respiratory probl	ems, and the hot, humid			potential change in condition, including assessing residents		
	air made it impo	ssible for her to breathe			daily.		
	easily and sleep.	Two fans were observed			·All residents will be assesse	ed	
	blowing on the r	esident. The resident's			thoroughly when the building		
	_	was at the bedside and			exceeds 81 degrees, with vital		
	_	a temperature reading in			taken, to ensure the comfort a safety of the resident. The	ina	
		om last evening when he			physician will be contacted for		
		cility. He indicated the			those presenting with a chang		
		egrees. The resident and			condition for further orders.		
		•			·The DNS/Designee will be		
	1	per indicated she was			responsible to ensure		
		nove to another room			compliance. Non-compliance will result i	in	
		r. The family member			further education including	"'	
	_	blem with the air			disciplinary actions.		
	_	s compounded by a leak			How the corrective action will	be	
	of hot water und	er the facility. The floor			monitored to ensure the defici		
	was observed to	be warm to the feet			practice will not recur, i.e., who		
	through the soles	s of the shoes.			quality assurance program will put into place?	ı be	
	-				·The CQI tool for change in		
	The clinical reco	ord for Resident C was			condition will be utilized weekl	_{ly x}	
		9/12 at 12:45 p.m. The			4 weeks, bi-weekly x 3 months		
	1 10 110 11 04 011 7/11	., 12 at 12. 10 p.m. 1110	1		1		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155697	B. WIN			07/20/	2012
NAME OF B				STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF P	PROVIDER OR SUPPLIEF	R		517 N L	ITTLE LEAGUE BLVD		
		AND SKILLED NURSING CENTER	₹	CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	resident's diagno	oses included, but were			monthly x 3 months, and quart	terly	
	not limited to, er	nd stage renal disease,			thereafter for 2 consecutive quarters.		
	pneumonia, obst	ructive sleep apnea,			Findings from the CQI proce	299	
	diabetes, corona	ry disease, anemia,			will be reviewed monthly and a		
	chronic pain syn	drome, seizure disorder.			action plan will be implemente		
					for thresholds below 95%.		
	and anniety.						
	An Emarganou I	Doom Consult dated					
		•					
		•					
	exacerbation. The	he resident was intubated					
	and placed on a	ventilator.					
	The Observation	Report for					
	Admission/Read	lmission, dated 6/8/12,					
	indicated the res	ident returned to the					
	facility on that d	ate.					
	-						
	Progress Notes,	dated 7/17/12, indicated					
	the following aft	ter 7:00 p.m. on that date:					
		N. 0005					
	•						
	. –						
	rags and ice pacl	ks applied to resident to					
	keep resident co	ol"					
	at 10:09 p.m., "F	Res refused to get up and					
	go to the mdr [M	fain Dining Room] or to					
	the therapy gym.	. Res is in room with 2					
	1.00						
	-						
	•						
	and anxiety. An Emergency F 6/1/12, indicated admitted to the hard related to an acurpulmonary disease exacerbation. The Observation Admission/Readindicated the restacility on that described by the following after at 7:14 p.m., " symptoms] of described by the following after at 10:09 p.m., "Figo to the mdr [Matther therapy gyment fans and ice packet of the parts of here."	he resident was intubated ventilator. Report for Imission, dated 6/8/12, ident returned to the ate. dated 7/17/12, indicated ter 7:00 p.m. on that date: No S&S [signs and ehydration noted. Cool ks applied to resident to ol" Res refused to get up and fain Dining Room] or to				d	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet Page 13 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN		NSTRUCTION 00	(X3) DATE S COMPL	ETED	
		155697	B. WING			07/20/	2012
	PROVIDER OR SUPPLIER	ND SKILLED NURSING CENTER	5 ⁻	17 N LI	DDRESS, CITY, STATE, ZIP CODE TTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
		d mucous membranes kin turgor good extra d accepted."					
	7/17/12 indicated respirations 18 per minute; temperat	ort at 10:12 p.m., on I blood pressure 104/58; er minute; pulse 100 per ure 98.9 degrees oxygen saturation of					
	Progress Notes, of the following:	dated 7/18/12, indicated					
	at 2:55 a.m., "io for comfort, no s.	ce packs applied to res/s dehydration					
		No s/s of dehydration e fluids and res accepted					
	p.m., indicated, respirations 20 pominute; temperat	blood pressure 130/66; er minute; pulse 88 per ure 98.2 degrees oxygen saturation of					
		No s&s of dehydration inue to encourage					
		on the Vital Signs Report Notes failed to indicate					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet

Page 14 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155697	B. WIN			07/20/	2012
NAME OF P	PROVIDER OR SUPPLIEF		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER	3	CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		al signs, including					
		re measured during the					
		onditioner malfunction					
		7:14 p.m., when ice packs					
	_	ool the resident's body,					
	until 7/18/12 at 2	2:28 p.m.					
	2. During interv	riew on 7/18/12 at 7:20					
		indicated, "I almost had					
	1 * '	night." She indicated					
		e under my arms." She					
	_	uldn't breathe, and "I					
		hale, it was so hot and					
		time, the resident was					
		e oxygen by nasal cannula					
		a plugged tracheostomy.					
		sident E's roommate					
		and indicated it was					
		here last night - the					
	I -	the hall said 89 or 90."					
	thermometer in t	ile hall salu 69 of 90.					
	During interview	v on 7/18/12 at 8:10 p.m.,					
	_	d you felt like you					
		breath anywhere in the					
		preceding evening.					
		8 8					
	The clinical reco	ord for Resident E was					
		9/12 at 12:50 p.m. The					
	record indicated	-					
		ling, but not limited to,					
	~	pleed with duodenal ulcer					
	status post EGD						
	_	oduodenoscopy), acute					
		quiring transfusion, polio					
		quilling transfasion, pono					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet

Page 15 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155697	B. WIN			07/20/	2012
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
OL ADICE		AND OKULED AUTDOING OFFITE	_		ITTLE LEAGUE BLVD		
		AND SKILLED NURSING CENTE	≺ 	CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DLI ICILIAC I)		DATE
		chronic tracheostomy,					
	1 7 1	1. The resident had a					
		nonia. A hospital					
	_	nary indicated the resident					
	_	back to the facility on					
	7/9/12.	N 6 7/17/10					
		ss Note for 7/17/12 was at					
	-	e the air conditioner					
	malfunction.						
	_	otes for 7/18/12 indicated					
	the following:						
	1 2 22 UD	/					
	-	es resting in bed. No s/s					
	1	oted. Encouraged fluids.					
	res drank 120 cc	•					
		en and unlabored. HOB					
		evated per request d/t [due					
		nts of] SOA [short of air]					
	when lying flat.	No concerns noted."					
		0.1.00.1.1					
		xtra fluids offered and					
	_	ssure of adequate					
	l -	turgor is good. HOB is					
		ent c/o being SOA when					
		oxygen] on per n/c [nasal					
	_	o respiratory distress at					
	this time."						
		7/10/10 : 2.54					
		ort on 7/18/12 at 3:56					
	_	he respirations were 19					
		saturation was 97%. No					
	1	including the resident's					
	-	re recorded for 7/17/12 or					
	7/18/12 when the	e air conditioner					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet Page 16 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPI	LETED
		155697	B. WIN			07/20	/2012
		1	11		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIE	R			ITTLE LEAGUE BLVD		
		AND SKILLED NURSING CENTE	R	CLARK	SVILLE, IN 47129		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	malfunctioned.						
		ocumentation related to					
	any vital signs n	neasured for Residents C					
	and E between 7	7/13/12 and 7/18/12 was					
	provided on the	conference room table on					
	7/20/12 at 9:15 a	a.m. Review of the vital					
	signs reports ind	licated information as					
	noted above.						
	The Interim Adr	ministrator provided the					
		related to emergency					
	*	7/19/12 at 11:35 a.m.					
	1 ^ ^	olicy indicated in Section					
	H, Loss of Utilit	•					
	1	or Cooling Failure:4. If					
	_	ches 82 F or higher, the					
		•					
		utions will be put into					
	_	ample cold fluids to					
		s residents for signs and					
	* *	at exhaustion/heat stroke					
		e, weakness, dizziness,					
	nausea and vom	iting."					
	On 7/23/12 at 0.	30 a.m., on-line review at					
		icinenet.com/heat stroke/					
		eated, "Heat stroke is a					
		·					
		ermia, an abnormally					
	elevated body te	•					
	accompanying p	hysical symptoms"					
	During the Exit	Conference on 7/20/12 at					
	2:35 p.m., any a	dditional information					
		fied concerns including					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet Page 17 of 34

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/20/2012
	ROVIDER OR SUPPLIER REHABILITATION AND SKILLED NURSING CENTER	517 N L	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD SVILLE, IN 47129	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	assessment of residents, was requested, and none was provided.			
	This federal tag relates to Complaint IN00112646.			
	3.1-37(a)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet

Page 18 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DI III	DDIC	00	COMPL	ETED
		155697	A. BUII			07/20/	2012
			B. WIN	_			_
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
		NE OWN ED ANDONIO OFFITED			LITTLE LEAGUE BLVD		
CLARK R	KEHABILITATION A	ND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0328	483.25(k)						
SS=D	` '	ARE FOR SPECIAL NEEDS					
		ensure that residents					
		eatment and care for the					
	following special						
	Injections;						
	Parenteral and e	enteral fluids;					
	Colostomy, urete	erostomy, or ileostomy care;					
	Tracheostomy ca	are;					
	Tracheal suction	ing;					
	Respiratory care	;					
	Foot care; and						
	Prostheses.						
	Based on observa	ations, interview, and	F03	28	What corrective action(s) will be	e	08/17/2012
	record review, the facility failed to ensure				accomplished for those reside		
	· ·	kygen therapy was initiated by licensed			found to have been affected by	y	
		-			the deficient practice?		
		esident reviewed related					
	to continuous ox	ygen administration in a			Resident C is receiving oxygen		
	sample of 9. (Res	sident C)			therapy by licensed staff per		
					physician order.		
	Findings include						
	i mamgs merade	•			How other residents having the	_	
					potential to be affected by the	5	
	On 7/18/12 at 8:4	40 p.m., Resident C was			same deficient practice will be		
	observed during	transfer from bed to			identified and what corrective		
	wheel chair by H	loyer lift. CNA #12 and			actions will be taken?		
	•	ed the resident for			actions will be talled.		
		ng switching the resident's					
	*	c c			·All residents have the poter	itial	
	oxygen tubing fr				to be affected by the alleged		
	concentrator to the	he portable oxygen tank.			deficient practice.		
	During interview	at this time, CNA #18			·All nursing personnel will be)	
	•	eck the level of oxygen in			re-educated by DNS/Designee		
		dicated she did not know			8/14/12 on oxygen therapy.		
					·All licensed nursing staff wil	l be	
		e level, but it felt heavy,			re-educated 8/14/12 by		
	but she would ad	ld oxygen to be sure.			DNS/Designee on their		
	CNA #12 indicat	ted she would check the			appropriate job descriptions,		
		and lifted the tank by the			explaining their scope of duties		
	it for in the turns,	and mode and talle by the			·CNA assignment sheets wil	l be	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet

Page 19 of 34

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л рин	DING	00	COMPLE	ГED
		155697	A. BUII B. WIN			07/20/2	012
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	R			ITTLE LEAGUE BLVD		
CLARKE	PEHARII ITATION A	AND SKILLED NURSING CENTER			SVILLE, IN 47129		
			1		OVILLE, IIV 47 123		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
	•	e tank was full. The			updated stating aides are not adjust oxygen liter flow at any	10	
		sing was in the room, and					
	she asked what level the oxygen was set on. CNA #12 indicated the level was on zero, since the portable tank was not in				time. •DNS/Designee is responsible		
					to ensure compliance.		
					·Non-compliance will result i	n	
	use at the mome	nt. The Director of			further education including		
	Nursing left the	room. When the oxygen			disciplinary actions.		
	_	ged from the concentrator					
		ank, CNA #12 indicated			What measures will be put into	o	
	•	the level on 2. CNA #12			place or what systematic char		
	_	resident, "You're on 2			will be made to ensure that the deficient practice does not rec		
					:ur?		
		me of Resident C]?"					
		CNA #12 she was on 3			·All nursing personnel will be	_	
		and CNA #12 set the			re-educated by DNS/Designer		
	tank at 3 liters.		8/14/12 on oxygen therapy.				
					·All licensed nursing staff wi	ll be	
	The clinical reco	ord for Resident C was			re-educated 8/14/12 by		
	reviewed on 7/19	9/12 at 12:45 p.m. The			DNS/Designee on their		
	record indicated	physician's orders for			appropriate job descriptions,		
		ling, but not limited to, an			explaining their scope of dutie ·CNA assignment sheets wil		
	-	dated 12/21/11, for			updated stating aides are not		
		cannula at 3 liters per			adjust oxygen liter flow at any		
	minute.	cumula at 5 liters per			time.		
	mmute.				·DNS/Designee is responsib	ole	
					to ensure compliance.		
	1.5	ertified Nursing Assistant			Non-compliance will result in	n	
	-	otion was provided on			further education including disciplinary actions.		
		p.m. The description			alcolphilary actions.		
	failed to indicate	e the CNA was					
	responsible for s	setting oxygen levels on			How the corrective action will		
	concentrators or	portable tanks.			monitored to ensure the defici		
					practice will not recur, i.e., who		
	3.1-47(a)(6)				quality assurance program wil put into place?	ı νe	
	- / ((() ())				γαι πιο μιασε:		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet

Page 20 of 34

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155697	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/20/2012			
	ROVIDER OR SUPPLIER	I : .ND SKILLED NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	The CQI audit on oxygen therapy will be utilized weekly bi-weekly x 2 months, monthl and quarterly thereafter for 2 consecutive quarters. Findings from the CQI proc will be review monthly and an action plan will be implemente for thresholds below 95%.	y x 4, y x3, cess			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet

Page 21 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE :	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155697	B. WIN			07/20/	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LITTLE LEAGUE BLVD		
CLARKE	PEHARII ITATION A	ND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0514	483.75(I)(1)						
SS=D	RES	//PLETE/ACCURATE/ACCE					
	SSIBLE	IFLETE/ACCORATE/ACCE					
		maintain clinical records on					
	_	accordance with accepted					
		ndards and practices that are					
		ately documented; readily					
	accessible; and	systematically organized.					
	The district second	and an anti-in-refficient					
		rd must contain sufficient entify the resident; a record					
		assessments; the plan of					
		s provided; the results of any					
		reening conducted by the					
	State; and progre	ess notes.					
	Based on observa	ation, record review and	F05	14	What corrective action(s) will b	е	08/17/2012
		cility failed to ensure			accomplished for those reside		
		the clinical record was			found to have been affected by	/	
		curate for 2 of 5 residents			the deficient practice?		
	whose records w						
		nple of 9. (Residents A			·Resident A continues to		
	and B)	ipie of 7. (Residents 11			receive treatments as indicate	-	
	aliu b)				by physician orders while in th	е	
					building.		
	Findings include	:			Resident B continues to	d	
					receive treatments as indicated by physician orders and any sl		
	1. On 7/18/12 at	8:15 p.m., LPN #11 was			issue is documented with	XII I	
	observed dressin	g a reddened area on the			measurements and description	าร	
	coccyx of Reside	ent A. During interview			as they apply.		
	at this time, LPN	#11 indicated the area					
	-	hough it had been in the				_	
	•	ndicated she was placing			How other residents having the	Э	
	•	ing on the area for			potential to be affected by the same deficient practice will be		
	-	ing on the area tor			identified and what corrective		
	protection.				actions will be taken?		
		10. 5. 11					
		rd for Resident A was					
	reviewed on 7/20	0/12 at 10:30 a.m. The			·All residents have the poten	tial	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet Page 22 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155697	A. BUII B. WIN			07/20/	2012
		1	b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	R			LITTLE LEAGUE BLVD		
CLARK I	REHABILITATION A	AND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
	record indicated				to be affect by the alleged		
	transferred to the	e hospital on 7/1 and			deficient practice. ·Licensed nursing staff will t	20	
	readmitted to the facility on 7/7/12. The Observation Report for				re-educated 8/14/12 by the) C	
					DNS/Designee on the		
					documentation guidelines poli	су	
		lmission, dated 7/7/12,			and procedure. Documentation	on	
		ident had "Discolorations			must be accurate, indicate		
	- coccyx."	racin ind Discolorations			location, and include a descrip	otion	
	- coccyx.				of the skin issue. •An audit of the treatment		
	D				records was completed on or	hv	
	Documentation in Progress Notes and				8/14/12 by DNS/Designee to	~,	
	physician's orders failed to indicate an				ensure completion and accura	асу.	
	order related to a	a treatment to the coccyx			·Treatment records will be		
	until 7/10/12, wl	hen a physician's order			checked daily to ensure		
	was received for	"Allevyn bandage to			completion and accuracy by		
	reddened area at	coccyx." The Care Plan			DNS/Designee. ·DNS/Designee is responsite.	مام	
	Update section of	of the Physician			to ensure compliance.	Л С	
	Telephone Orde	-			·Non-compliance will result	in	
	"Clarification."	,			further education including		
					disciplinary actions.		
	The resident's Tr	reatment Administration					
	Record for July	1 through July 31, 2012,			What measures will be put int	0	
	1	urses' initials that the			place or what systematic char	nges	
		n dressing was applied			will be made to ensure that th		
	1	to 11:00 p.m. shift on all			deficient practice does not rec	cur?	
	_	2 through 7/19/12,					
		tes the resident was in the			Licensed nursing staff will b	oe .	
	1				re-educated 8/14/12 by the		
	hospital. The sa				DNS/Designee on the		
		Record indicated with			documentation guidelines poli		
	nurses' initials th	_			and procedure. Documentation	on	
		een implemented on all			must be accurate, indicate location, and include a descrip	ntion	
		uly 1 through July 19,			of the skin issue.	Juon	
	2012: "Keep rig	tht knee and lower leg			·An audit of the treatment		
	elevated while a	bed to decrease edema r/t			records was completed on or	by	
	[related to] arthr	itic swelling and			8/14/12 by DNS/Designee to		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	DDIC	00	COMPL	ETED
		155697		LDING		07/20/	2012
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	R			ITTLE LEAGUE BLVD		
CLVDKL	DEHARII ITATION A	AND SKILLED NURSING CENTER					
	AELIADILITATION A	AND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	1	TAG			DATE
	inflammation."				ensure completion and accura	acy.	
					·Treatment records will be		
	During interview	v completed on 7/20/12 at			checked daily to ensure completion and accuracy by		
	_	irector of Nursing			DNS/Designee.		
	_	as unable to locate a	1		·DNS/Designee is responsit	ole	
		r for the dressing change			to ensure compliance.	-	
					Non-compliance will result	in	
	prior to the clari	fication order on 7/10/12.			further education including		
					disciplinary actions.		
	_	v on 7/20/12 at 2:20 p.m.,	1				
	in regard to the	Treatment Administration			How the corrective action will	ho	
	Record indicating	ng treatments were			monitored to ensure the defici		
	provided while t				practice will not recur, i.e., wh		
	•	Director of Nursing			quality assurance program wi		
	indicated, "I thir	<u> </u>			put into place?		
	happened."	III I IIIO II IIIIII					
	паррепец.						
	0 0 5/00/10	10.05			·The CQI audit tool on		
		t 12:25 p.m., LPN #11			MAR/TAR flow sheet will be	v 2	
		ompleting dressing	1		utilized weekly x 4, bi-weekly months, monthly x3, and quar		
	changes to butto	cks wounds of Resident			thereafter for 2 consecutive	СПУ	
	B. LPN #11 ind	licated the physician had			quarters.		
	revised the order	rs related to the wounds,			·Findings from the CQI prod	ess	
		be the first time the new			will be review monthly and an		
	orders were in e				action plan will be implemente	ed	
	orders were in c.	11001.			for thresholds below 95%.		
	The allowing to	and fan Daaidant D	1				
		ord for Resident B was					
		9/12 at 11:00 a.m. The					
		the resident was	1				
	readmitted from	the hospital on 6/28/12.					
	A Physician's Te	elephone Order, dated					
	_	d, but was not limited to,					
	=	open areas] to (B)					
	-						
	_	cks [symbol for with] NS					
	Inormal saline]	pat dry apply Bacitracin &	1				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/20/2012
	PROVIDER OR SUPPLIEI	R AND SKILLED NURSING CENTE	517 N I	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD SVILLE, IN 47129	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	cover with Allev needed]."	yyn QD [daily] & prn [as			
	Skin Integrity Education of the	in Progress Notes and vents failed to indicate a e wounds identified on Telephone Order on			
	1:15 p.m., the A Nursing indicate B's wounds on 7 description was records. She pr "Skin Integrity F Date" of 7/14/12 of 7/20/12 at 12: 12:29 p.m. and i was on the "Con Integrity Events	on the "Composite" ovided copies of three Events" indicating "Event and "Completed Date" 24 p.m., 12:26 p.m., and ndicated the information apposite." The Skin were related to two off buttock and one wound			
	1:20 p.m., the In provided copies Pressure Wound Reports." The I indicated the docreports related to had been transcript At the end of the	v completed on 7/20/12 at sterim Administrator of "Composite Report Skin Evaluation Interim Administrator cumentation on the Paragraph Resident B's wounds libed from other reports. The form was written, and report is a CQI			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet

Page 25 of 34

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697 A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/20/2012
NAME OF PROVIDER OR SUPPLIER CLARK REHABILITATION AND SKILLED NURSING CENTER STREET ADDRESS, CITY, S 517 N LITTLE LEAGU CLARKSVILLE, IN 47	JE BLVD
PREFIX (EACH DEFICIENCY MUST BE DEPCEDED BY FULL DEFIX (EACH CORREC	CS PLAN OF CORRECTION TIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
[Continuous Quality Improvement] document for internal use only."	
This federal tag relates to Complaint IN00112646.	
3.1-50(a)(1) 3.1-50(a)(2)	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet

Page 26 of 34

		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	00	COMPLETED	
		155697	B. WING 07/20/2012				
NAME OF P	DOWNED OF CLIDAL ICA		STE	REET A	DDRESS, CITY, STATE, ZIP CODE	•	
NAME OF P	ROVIDER OR SUPPLIER		51	7 N LI	TTLE LEAGUE BLVD		
	REHABILITATION A	ND SKILLED NURSING CENTER	CL	ARKS	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	G	DEFICIENCY)		DATE
F0517 SS=E	483.75(m)(1) WRITTEN PLAN	IS TO MEET					
33-E	EMERGENCIES						
		have detailed written plans					
		to meet all potential					
	•	d disasters, such as fire,					
	severe weather,	and missing residents.					
	Based on observa	ation, interview, and	F0517		What corrective action(s) will be		08/17/2012
	record review, th	e facility failed to ensure			accomplished for those reside		
	its Disaster Polic	ey and Procedures related			found to have been affected by the deficient practice?	у	
		oning outage were			ine delicient practice:		
		eficient practice affected			· Resident C has been moved		
		observed whose room			to a room that is within normal		
		re outside planned			temperature range of 71-81 degrees	s.	
	•	•			· Resident F's PTAC unit has		
		meters in a sample of 9.			been repaired and is within normal $% \left(1\right) =\left(1\right) \left(1$		
	(Residents C, F,	G, and H)			temperature range of 71-81 degrees	S.	
					· Resident H's room is within		
	Findings include	:			normal temperature range of 71-81		
					degrees.		
	The Interim Adn	ninistrator provided the			Resident G's room is within		
	facility's binder r	related to emergency			normal temperature range of 71-81 degrees.		
	preparedness on	7/19/12 at 11:35 a.m.			degrees.		
		olicy indicated in Section					
	H, Loss of Utiliti	-			How other residents having the	е	
	· ·	or Cooling Failure:7.			potential to be affected by the		
	Ambient air tem				same deficient practice will be		
	-	ocumented for various			identified and what corrective		
		nout the building such as			actions will be taken?		
	_	•			· All residents have the		
		nges and a sampling of			potential to be affected by the		
		.3. [sic] If temperatures			alleged deficient practice.		
		ed between 71 - 81			· All staff in service will be hel	d	
		enance Director will			on 8/14/12 by ED/Designee to		
		source of heating or			education staff on the disaster		
	cooling until repa	airs are complete. 4. If			manual and locations of the manual		
	temperature reac	hes 82 F or higher, the			in the event of a disaster.		
	•	<u> </u>			 All PTAC units within the 		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet Page 27 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SU	RVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED			
		155697	B. WING				07/20/2012	
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER							
		ND SKILLED NURSING CENTER			ITTLE LEAGUE BLVD			
CLARK	KENABILITATION A	IND SKILLED NORSING CENTER		CLARK	SVILLE, IN 47129			
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE (COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	following precau	tions will be put into			facility were checked on or by			
	place:Provide	ample cold fluids to			8/13/12 to ensure proper			
	residents"	p			functioning.			
	residents				· All rooms within the facility			
	D · · · ·	4 1 1 1 1 7			were checked on or by 8/13/12 to			
		on the Initial Tour on			ensure temperatures were within			
	7/18/12 at 4:35 p	o.m., the Interim			normal range of 71-81 degrees.			
	Administrator in	dicated the facility			· Hot water pipes within the			
	recently had prob	olems with the air			facility have been checked on or by			
		tem. She indicated the			8/3/12 and all pipes indicating leaks			
	"	unctioned on Friday			have been repaired by 8/3/12.			
	~	<u> </u>			· A temporary chiller unit will			
	` ''	paired on Saturday			be delivered on or by 8/13/12 to			
		power surge in the city on			ensure the temperatures within the			
	Tuesday morning	g (7/17/12) had caused			building are between 71-81 degrees			
	another malfunct	tion of the system. She			while the repairs to our existing			
	indicated the fac	ility's regular heating and			chiller unit take place, ensuring our			
		provider, and another			current system will permanently			
		ing service provider, had			reach its maximum cooling			
					potential.			
		em on Tuesday (7/17/12).						
		ninistrator indicated			What magaires will be put into			
	temperatures in t	he hallways were being			What measures will be put into place or what systematic chan			
	tracked.				will be made to ensure that the	-		
					deficient practice does not reci			
	During interview	on 7/18/12 at 7:00 p.m.,						
	1	inistrator indicated her						
		for all areas of the			· All PTAC units within the			
	1				facility were checked on or by			
	_	ween 71 and 81 degrees			8/13/12 to ensure proper			
		reiterated that logs were			functioning.			
	being maintained	I for temperature in the			· All rooms within the facility			
	hallways				were checked on or by 8/13/12 to			
					ensure temperatures were within			
	1 During observ	vation in the Room of			normal range of 71-81 degrees.			
i		18/12 at 5:20 p.m., a			· All staff in service will be hel	d		
		• •			on 8/14/12 by ED/Designee to			
		ge reading indicated 85.9			education staff on the disaster			
	degrees F when i	measured in the vicinity			manual and locations of the manual			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet Page 28 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3)			3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
155697		B. WIN		07/20/2012			
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE	
	where Resident	F was seated in his wheel			in the event of a disaster.		
	chair near the PT	AC [packaged terminal			· Disaster manual will be		
	air conditioner] u				reviewed and updated to ensure all		
	_	oom, and Resident F had			policies and procedures are		
					accurately followed in the event of a	3	
	_	water pitcher nearby.			disaster. The policy will be		
	_	from the PTAC unit, but			monitored by the ED/Designee		
		el cool to the touch.			during the event of an air		
	_	at the time, Resident F			conditioning outage. Hot water pipes within the		
	indicated he had	opened his windows			facility have been checked on or by		
	earlier in the day	to try to get some cool			8/3/12 and all pipes indicating leaks		
	air, but "me and	the lady that runs this			have been repaired by 8/3/12.		
	place talked," and	d she told him to close			· A temporary chiller unit will		
	the windows so t	he PTAC could cool the			be delivered on or by 8/13/12 to		
	room. The reside	ent indicated, "I'm			ensure the temperatures within the		
		og" and "It's too hot to			building are between 71-81 degrees	i	
	_	ated the air coming from			while the repairs to our existing		
		ing unit was not cool.			chiller unit take place, ensuring our		
		cated he kept wiping his			current system will permanently		
		vash cloth to keep cool,			reach its maximum cooling potential.		
		_			potential.		
	_	a wash cloth folded on					
		resident indicated he did			How the corrective action will be	ре	
	_	lass or water pitcher in			monitored to ensure the deficie	ent	
		esident indicated the			practice will not recur, i.e., wha		
	^	on the overbed table next			quality assurance program will put into place?	pe	
	to the roommate'	s bed belonged to the			put into place?		
	roommate.						
					·Resident rooms on each ha	ll e	
	At this time, the	Interim Administrator			and common areas will be		
		and discussed the room			checked by		
	temperature, lack	of fan, and lack of ice			Maintenance/Designee daily to	•	
	_				T	lou	
					·Maintenance		
					Director/Designee will provide		
		_			operation checks to the chiller		
	water for Resider Resident F indica taste of the water	of fan, and lack of ice and F. At this time, ated he did not like the at the facility. The trator indicated the			ensure temperature is maintain between 71-81 degrees. ·Maintenance Director/Designee will provide	ned	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet Page 29 of 34

i ´		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
I 155697 ■		A. BUILDING 00			COMPLETED	
		B. WIN	G		07/20/2012	
NAME OF B	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
TWINE OF T	KO VIDEK OK GOTT EIEN				ITTLE LEAGUE BLVD	
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER	1	CLARK	SVILLE, IN 47129	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	system to ensure proper	DATE
	l *	ave bottled water. Other			functioning weekly x 4, bi-weel	klv
		offered. The Interim			x 2 months, monthly x3 and	,
		ft the room, and at 5:25			quarterly thereafter for 2	
	_	ntered the room with ice			consecutive quarters.	
		nt F's roommate, and the			·Maintenance Director/Designee will provide	
		trator entered with water			operation checks on the PTAC	;
		The Maintenance			units in resident rooms to ensu	•
	-	entered the room,			proper functioning weekly x4,	
		erature gauge device, and			bi-weekly x2 month, monthly x and quarterly thereafter for 2	J
		temperature was 88			consecutive quarters.	
	~	Maintenance Supervisor			·Maintenance	
		C and indicated it			Director/Designee will keep a	
	_	en - it's not clicking			temperature log to ensure the building is within normal	
	_	The Maintenance			temperature range weekly x4,	
	•	ated the unit was not			bi-weekly x2 months, monthly	x3
	1	, although staff tended to			and quarterly thereafter for 2	
	· ·	out the unit was part of		consecutive quarters. The results of these audits will	, dill	
	1	n, which operates by			be reviewed by the CQI	WIII
		ving through the system,			committee. If threshold of 95%	% is
		om by room to adjust the			not achieved an action plan wi	II
	_	esidents' rooms. The			be developed to ensure	
	_	pervisor obtained tools,			compliance.	
		nt of the air conditioning				
	'	tments, and air cool to				
	1	to flow from the unit.				
		ninistrator brought in and				
	set up a fan in th	e resident's room.				
	_	iew on 7/18/12 at 5:35				
	1 -	indicated her room was				
		stay in. She indicated it				
		ght before, she had to				
	_	on her body to stay cool.				
	She indicated she	e has respiratory				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet

Page 30 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
	155697		B. WIN	G		07/20/	2012
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
					ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTE	₹	CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	•	e hot, humid air made it					
	•	er to breathe easily and					
	_	were observed blowing					
		The resident's family					
		he bedside and indicated					
	-	rature reading in the					
		ast evening when he					
		cility. He indicated the					
	room was 105 de	egrees. The resident and					
	the family memb	per indicated she was					
	preparing for a n	nove to another room					
	which was coole	er.					
	On 7/18/12 at 7:	55 p.m., another					
	interview was co	ompleted with Resident C.					
		icated she was waiting for					
		g the Hoyer lift to transfer					
	· ·	chair and take her bed to					
	her cooler room.	When CNA #12 entered					
		sident C indicated she					
	•	able breathing," and she					
	_	ng treatment before the					
		entered the room to					
	administer the tr						
		ne room measured 87					
	degrees F.	ie room measured o/					
	degrees 1.						
	On 7/18/12 at 8:	40 p.m., Resident C was					
		transfer from bed to					
	_	loyer lift. During the					
	1	esident was lowered into					
	· ·						
	·	ident indicated, "I can't					
	breathe. Let me						
	temperature in th	ne room measured 86.6					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet Page 31 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLET			ETED	
	I 155697		B. WING 07/20/2012				
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	t.			ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	l `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	TAG	DEFICIENCY)		DATE
	_	resident was wheeled out					
		ast four hours after the					
	_	e move to a cooler					
	location.						
	3. On 7/18/12 at	6:55 p.m., the					
	temperature in th	ne room of Residents G	1				
	and H was meas	ured at 86 degrees F.					
	Resident G was	observed in bed with					
	privacy curtains	partially closed around					
		s were closed, and his					
	_	e even. His supper tray					
	-	bed table in front of him.					
		e Maintenance Supervisor					
	_	nperature at 94 degrees F					
		indicated his high					
		_					
	_	surement was related to					
	·	g a temperature reading					
	from the floor of	the room.					
ı		00 p.m., Resident H had					
	returned to his ro	oom. He was seated in					
	his wheel chair n	nanipulating oxygen	1				
	tubing for his na	sal cannula. Resident H					
	indicated, "It's pr	retty daggone hot - hotter					
	than fire - in here	e." He indicated he had					
	opened the wind	ow to get air. At this					
	_	Administrator entered					
		Fered to move Residents					
		oler room, but both					
		anted to stay in their own					
	<u> </u>	H said about Resident G,	1				
		heat better than I can."					
	UNA #12 entere	d the room to remove	1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet Page 32 of 34

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697		A. BUILDING B. WING			COMPLETED 07/20/2012		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				LITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	1	. She asked Resident G,					
		?" She indicated he					
		xcept his dessert for					
	supper.						
	On 7/20/12 at 9:1	5 a.m., the Interim					
	Administrator pro	ovided her file related to					
	the repairs on the	air conditioning and the					
	logs of temperatu	ire checks in the					
	building. The log	gs indicated the					
	following:						
	S						
	Temperatures we	ere measured in the					
	-	of the four facility halls,					
		, dining room, and					
		7/17/12 at 6:30 p.m.,					
	7:30 p.m., and 8:3	•					
	_	he hallways ranged					
	between 84 and 1						
	_	re measured in any					
	residents' rooms	on //1//12.					
	On 7/18/12, temp	peratures were measured					
	, ,	lining room, 60 Hall					
	<u> </u>	Hall Lounge at hourly					
	• .	30 through 11:30 a.m.					
		were between 72 and 82					
	_	peratures were measured					
	-	nd 60 and 20 Hall					
	1	y intervals from 12:30					
		The temperatures					
		-					
		o 84 degrees F. No					
	•	re measured in any					
	residents' rooms	on //18/12.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet Page 33 of 34

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155697	A. BUIL B. WINC	DING	00	COMPL 07/20/	ETED
NAME OF PROVIDER OR SUPPLIER CLARK REHABILITATION AND SKILLED NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	the Interim Adm checks on room completed until a related to temper rooms.	on 7/20/12 at 1:20 p.m., inistrator indicated no temperatures had been after she was interviewed ratures in residents' relates to Complaint					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HMD611

Facility ID: 000059

If continuation sheet Page 34 of 34